STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G314	A. BUILDING _____ B. WING _____	R 05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREY SERVICES INC.	369 S SECOND ST UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was a post-certification revisit (PCR) to the extended annual recertification and state licensure survey conducted on March 30, 2012. Date of survey: May 2, 2012. Facility Number: 000833 Provider Number: 15G314 AIMS Number: 100243960 Surveyor: Claudia Ramirez, RN, Public Health Nurse Surveyor III/QMRP Carey Services Inc. was found to be in compliance with 42 CFR, part 483, subpart I, and 460 IAC 9 in regard to the PCR to the extended annual recertification and state licensure survey. Quality Review completed 5/9/12 by Ruth Shackelford, Medical Surveyor III.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.